MICHIGAN DEPARTMENT OF CONSUMER & INDUSTRY SERVICES
BUREAU OF HEALTH SYSTEMS
DIVISION OF NURSING HOME MONITORING
and
DIVISION OF OPERATIONS

THE PROCESS FOR CORRECTION OF DEFICIENCIES IN LONG TERM CARE FACILITIES

Revised April 18, 2002

Whenever a deficiency is cited in a long term care facility, it is necessary for the facility to act to correct it as soon as possible and for the Michigan Department of Consumer & Industry Services (MDCIS) to verify the correction. This document defines terminology and outlines the processes that both parties must follow during this process. It also contains detailed guidelines for facility preparation of Plans of Correction (PoC).

I. DEFINITIONS

A. Scope and severity

This term indicates the level (A through L) assigned to a deficiency on the Centers for Medicare & Medicaid Services (CMS) scope and severity "grid".

B. Plan of Correction (PoC)

This term indicates the facility plan of action and commitment to correct each deficiency by a specific completion date. An acceptable PoC is required for all deficiencies cited at scope and severity Levels B and above. When more than one deficiency is cited, the PoC for each deficiency must be acceptable in order for the overall PoC to be deemed acceptable by MDCIS. Detailed guidance on PoC requirements is contained in Part III. The PoC is due ten (10) calendar days after receipt of the *HCFA-2567L* by the facility.

C. Compliance

This term indicates that no deficiencies have been cited at any scope and severity level.

D. Substantial compliance

This term indicates that there are no deficiencies at scope and severity Level D or above. When all deficiencies are at Level C or below, the facility is in compliance for OBRA enforcement purposes.

E. Noncompliance

This term indicates any deficiency at scope and severity Level D or above. A facility is noncompliant until any or all deficiencies are corrected or their scope and severity is at Level C or below. If more than one deficiency is cited, the **latest** of the correction dates in the PoC is

considered to be the date on which the facility is alleging that it will attain, or has already attained, substantial compliance for all deficiencies.

F. Follow-up

This is a generic term referring to MDCIS evaluation and determination regarding facility correction of citations. This may occur through the use of an **onsite revisit,** or through **facility presentation of evidence of correction of deficiencies.** No follow-up is required for standard, abbreviated standard, or revisit surveys in which the highest-level deficiencies are at Levels A, B or C. However, the facility must submit an acceptable PoC for Level B or C deficiencies and is expected to make corrections.

II. PROCESSES FOR VERIFICATION OF COMPLIANCE

A. Facility presentation of evidence of correction in lieu of revisits

A revisit may be conducted at any time for any level of non-compliance. However, MDCIS **may** allow a facility to present acceptable evidence of correction in lieu of revisit if a survey does not find non-compliance at scope and severity Level F (with substandard quality of care) or at Levels G through L. Evidence of compliance in lieu of a revisit **is not allowed** after a second revisit has been conducted.

If a facility meets the criteria for presentation of evidence of correction as outlined above, a letter and a form is sent to the facility. Completed forms are processed by MDCIS and the facility is notified of results. If the evidence is not accepted, an onsite revisit must be conducted.

Examples of acceptable evidence are:

- An invoice or receipt verifying purchases, repairs, etc.,
- Sign-in sheets verifying attendance of staff at in-service training,
- Interviews with more than one training participant about training,
- Contact with resident council, e.g., when dignity issues are involved.

The compliance date when a facility has submitted acceptable evidence in lieu of a revisit is the date the evidence indicates the facility is in substantial compliance.

B. Onsite revisit

1. Revisit protocol

An onsite revisit is **required** whenever a survey finds non-compliance at scope and severity level F (with substandard quality of care) or at levels G through L. In such cases, revisits must continue for all citations until compliance is achieved with the originally cited level F (with substandard quality of care) or levels G through L citations.

The onsite revisit is conducted in accordance with a standard revisit protocol. As part of the revisit, the facility must be prepared to demonstrate the actual correction of each deficiency and the date on which the correction occurred. In order for a deficiency to be considered corrected, the facility must show that it has completed all four of the four required PoC criteria, including monitoring its corrective actions to ensure that the deficiency will not recur. The facility can typically show evidence of monitoring by summarizing the quality assurance steps it has taken to ensure maintained compliance.

2. Revisit timing and facility setting of the PoC correction date

Revisits occur on or after the latest correction date in the approved PoC. Since CMS requires MDCIS to conduct the first revisit within 60 days of the survey exit date, the latest correction date in the approved PoC for the survey that starts an enforcement cycle cannot exceed 50 days.

The purpose of the revisit is to confirm the facility is in substantial compliance and, in certain cases, has the ability to remain in substantial compliance. Facilities should remember this in selecting their PoC completion date. In many cases, a minimum period of 7-10 days beyond the PoC completion date is needed to determine that a facility has remained in substantial compliance. A facility ***should not assume*** the revisit will occur immediately after the completion date.

Facilities should pick the earliest possible completion date based on how the PoC relates to the 90th or 180th day of the enforcement cycle. A facility must be certified in substantial compliance before the 90th day to avert mandatory denial of payment for new admissions and substantial compliance must be certified before the 180th day to avoid termination. Facilities that have pending revisits for two or more surveys should try to establish approximately the same PoC completion dates for the surveys, if possible.

3. Impact of "Opportunity to Correct" versus "No Opportunity to Correct" on PoC completion date

Required dates of completion will vary based on the compliance history of the facility and how much time the facility determines will be required to correct the specific citation.

Facilities that meet the criteria for "**Opportunity to Correct"** will be given an opportunity to correct **before** imposition of enforcement remedies. A deadline for attainment of substantial compliance is provided in the MDCIS letter that transmits the *HCFA 2567L* to the facility. This date establishes the **maximum** allowable completion date for all deficiencies and **cannot exceed 50 days from the exit date of the initial survey within a cycle**, counting the exit date as Day One. Many deficiencies can be corrected in a shorter time frame. Citations related to direct resident care, such as medication administration, repositioning, ambulation, etc., can and should be corrected **immediately**.

Facilities that meet the criteria for **"No Opportunity to Correct"** will have remedies imposed **immediately** after a determination of noncompliance has been made. The criteria for "No Opportunity to Correct" are:

- The facility has deficiencies of actual harm (Level G) or above on the current survey, and on the previous standard survey or any intervening survey, i.e., any survey between the current survey and the last standard survey, **or**
- The facility was previously terminated and has deficiencies causing actual harm on the first survey after re-entry into the Medicare/Medicaid program, **or**
- The facility has immediate jeopardy. Removal of immediate jeopardy may, at CMS's discretion, result in rescission of a termination; it will not result in rescission of alternative remedies such as civil money penalties or denial of payment for new admission, **or**
- The facility has noncompliance for which a civil money penalty, denial of payment for new admissions, or denial of payment for all admissions was imposed.

The shorter the correction period, the lesser the enforcement remedies sustained by the "No Opportunity to Correct" facility. Dates of completion for citations at the immediate jeopardy level must reflect **immediate removal of serious harm or potential serious harm** to residents. Dates of completion for other deficiencies must reflect the shortest time frame that is appropriate for correction of each deficiency but **cannot exceed 50 days from the exit date of the initial survey**, counting the exit date as Day One. Citations related to direct resident care can and should be corrected immediately.

4. Limit on number of revisits

CIS is authorized to conduct two revisits per enforcement cycle; this includes abbreviated surveys ***and*** standard survey revisits. A remedy must be imposed when the facility is not in compliance on the second revisit.

The Centers for Medicare and Medicaid Services (CMS) Regional Office can authorize a third revisit; the CMS Central Office can authorize a fourth revisit. A PoC must be received and approved by CIS and then submitted to CMS with each revisit request. A fourth revisit requires justification. The facility must be terminated if CMS denies a revisit.

Due to these revisit restrictions, the MDCIS is required to attempt to coordinate and consolidate revisits for standard surveys, abbreviated surveys, and multiple abbreviated surveys. It will occasionally be necessary to delay a revisit until a PoC for either an outstanding standard or abbreviated survey is received. In some cases it has been necessary to consolidate and conduct revisits after the 90^{th} day of the enforcement cycle to stay within the two revisit limit.

5. Compliance date determination

The revisit date is the compliance date (when correction is verified), except when:

- The revisit determines all deficiencies have been corrected,
- The facility is in substantial compliance, **and**
- The facility provides acceptable evidence to establish a compliance date prior to the first or second revisit date.

Compliance (when correction is verified) is certified as of the date of the 3rd or 4th revisit. CMS does not allow a compliance date earlier than the revisit date for the third or subsequent revisits.

Where more than one deficiency is involved, the date on which the facility is considered to be in compliance is the **latest** of the correction dates for the deficiencies. This date would typically be the alleged compliance date submitted earlier by the facility.

It should be noted that for OBRA enforcement purposes, remedies cease when the facility is either in compliance or in substantial compliance. Therefore, if deficiencies are not corrected, but yet reduced to substantial compliance level, the substantial compliance date(s) for each deficiency and for the facility overall are evaluated in the same manner as described above.

III. GUIDELINES FOR THE DEVELOPMENT OF A PLAN OF CORRECTION FOR LONG TERM CARE FACILITIES

The Plan of Correction (PoC) is the facility's plan of action and commitment to correct each deficiency no later than a specific completion date. **Submission of an acceptable PoC is required for all deficiencies of scope and severity Levels B through L.**

A. Time frame for submission of an acceptable PoC

The facility must submit an acceptable PoC within 10 calendar days of receipt of its *HCFA-2567L*. The facility is encouraged to submit a PoC as soon as possible to allow for the possibility that the plan may not be accepted and thus require resubmission before the 10th calendar day after it receives its *HCFA-2567L*.

Although the actual *HCFA-2567L* will not be presented at the exit conference, sufficient information regarding tentative citations will be given by the surveyor(s) to enable the facility to begin development of the PoC for those deficiencies. **The facility should start developing the PoC immediately after the exit conference.** The OBRA enforcement system recognizes and rewards prompt corrective action by a noncompliant facility.

B. Overall purpose of the PoC

The nursing home reform regulation establishes several expectations. The primary expectation is that facilities remain in substantial compliance with Medicare/Medicaid program requirements as well as State law. It emphasizes the need for continued, rather than cyclical, compliance. The process mandates that policies and procedures be established to **promptly** remedy deficient practices and to ensure that correction is lasting; specifically, that facilities take the initiative and responsibility for monitoring their own performance continuously to sustain compliance. Measures such as the revised requirements for a PoC emphasize the ability to achieve and maintain compliance, leading to improved quality of care.

C. Content of the PoC

1. **All** deficiencies cited in the *HCFA-2567L* must be individually addressed in the PoC.

2. The PoC must **not** include resident or facility staff names, allude to another facility or supplier, or malign an individual. Resident or staff identifiers used by MDCIS in the statement of deficiencies may be used in the PoC.

3. The facility should do an in-depth analysis to ascertain why the problem exists and occurred so as to develop solutions necessary to achieve resolution and sustain compliance.

4. The required content of the PoC for each deficiency depends upon whether the deficiency is **resident-centered** or **facility-centered** as outlined below:

   ### a. Resident-centered deficiencies

   Resident-centered deficiencies are violations of requirements that must be met for each resident. Examples of such deficiencies include failure to prevent pressure sores, protect the dignity of residents, provide notice prior to transfer, and adequately assess residents.

   The PoC for such resident-centered deficiencies must include the following four (4) elements:

   (1) How corrective action has been or/will be accomplished for those residents found to have been affected by the deficient practice;

   (2) How the facility has identified or will identify other residents having the potential to be affected by the same deficient practice;

   (3) What measures have been or will be put into place or systemic changes made to ensure that the deficient practice will not recur; and

(4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what quality assurance program will be put into place. (*Note:* Who, within your organization, will be responsible for assuring that substantial compliance is **attained** through the PoC and within the allowable time frames **and** who will be responsible for sustained compliance thereafter?).

To clarify further for Element (1), the PoC for resident-centered deficiencies should give a general accounting of how the deficiencies cited during the survey for a specific resident have been corrected. It should be noted that the residents cited represent those examples discovered from the resident samples used in the survey. Element (2) must state how all other residents who have been, or could be, affected by the generic deficient practice have been identified. Elements (3) and (4) must demonstrate that the facility has considered all residents in their plan development.

Corrective measures facilities should consider for Elements (3) and (4) of their PoC include, but are not limited to:

Element 3: Examples
- In-service training
- Off-site training
- Information sharing with other facilities
- Use of consultants
- Interdisciplinary, multi-level quality improvement teams
- Resident Council input
- Ombudsman input
- Physical environment enhancements
- Expansion of staff numbers/qualifications
- Staff supervision and discipline

Element 4: Examples
- Oversight by DON or other management personnel
- Customer surveys
- Resident Council feedback
- Ombudsman feedback
- Interviews with residents and families

b. Facility-centered deficiencies

Facility-centered deficiencies are violations of requirements that must be met for the facility overall. In general, these are "system" deficiencies such as lack of an infection control program, inadequate staffing, or an inoperative fire alarm system.

The PoC for facility-centered deficiencies must include the following three elements:

(1) How corrective action has been or will be accomplished for the facility-centered deficient practice;

(2) What measures have been or will be put into place or systemic changes made to ensure that the deficient practice will not recur; and

(3) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what quality assurance program will be put into place.

*NOTE: Some regulatory requirements (Example: F 248) deal with both individual residents **and** facility systems. For deficiencies that have both facets, be sure to address each facet in the corrective response.*

D. PoC completion dates

1. A **single** date of completion (month, day, year) must be entered in the right-hand column of the *HCFA-2567L* for **each** deficiency. This date should appear opposite the "F tag" which appears in the left-hand column at the beginning of the deficiency. This must be done even if the PoC for a particular deficiency is cross-referenced from the PoC of another deficiency. Only **one** PoC date is allowed for each deficiency. For some types of deficiencies such as physical environment, it may be appropriate to show separate completion dates for correction of specific items. In some cases, these dates should appear in the PoC text itself, not in the right-hand column. The **overall** completion date for all of the items within that citation should be the one that appears in the right-hand column opposite the tag number as noted above.

2. The earliest allowable correction date is **one day after the survey completion date** shown at the top of the report.

3. **See Part II.B for detailed considerations in setting the POC completion dates**.

E. Disputing deficiencies

Please refer to the MDCIS *Informal Deficiency Dispute Resolution for LTC Facilities* document for the process for submitting Level 2 requests for IDDR review of deficiencies. If a Level 2 request is submitted for a deficiency, the facility may acknowledge its submission by placing the following statement **at the beginning** of the PoC for each deficiency in question.

"The facility objects to this deficiency and has invoked its right to utilize the Informal Deficiency Dispute Resolution process for Tag _____."

Any Level 2 IDDR Request forms and attachments thereto can be submitted at the same time as the PoC but must be separable from the PoC and its attachments for IDDR processing purposes.

At its discretion, the facility may post the IDDR Request forms and attachments along with the *HCFA-2567L* in the facility.

F. PoC used as an allegation of compliance

The PoC is automatically considered to be the facility's allegation of compliance as of the latest PoC correction date given in the PoC.

G. Attachments to PoC

In an effort to streamline the PoC development and review process for both facilities and survey agency personnel, facilities are asked to restrict PoC attachments to only those documents that are necessary to support the specific contents contained within the PoC. Extraneous materials are of no value and may result in unnecessary delays to the process.

H. Questions regarding the PoC process

Facility questions regarding all aspects of the PoC process may be directed to the Licensing Officer that transmitted the enforcement letter requesting the PoC.